Palliative Care Academic Career Awards

Policy Report

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A Public-Private Partnership to Improve Care for the Most Vulnerable

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The International Longevity Center–USA (ILC–USA) is a not-for-profit, nonpartisan research, education, and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and to highlight older people's productivity and contributions to their families and society as a whole.

The organization is part of a multinational research and education consortium, which includes centers in the United States, Japan, Great Britain, France, and the Dominican Republic. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

The Center to Advance Palliative Care (CAPC), a national initiative funded by the Robert Wood Johnson Foundation with technical assistance provided by Mount Sinai School of Medicine, is dedicated to increasing the availability of quality palliative care services for seriously ill patients and their families in hospitals and other health care settings.

CAPC is the national resource center for hospitals and health systems interested in developing palliative care programs. CAPC serves a broad constituency of palliative care advocates, providers, and administrators—including physicians, nurses, educators, hospital managers, policymakers, health researchers, payers, and, ultimately, patients and their families—in an effort to improve the availability and quality of palliative care.

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Executive Summary

The exponential growth in the number of older adults represents a health care challenge of enormous scope and complexity in the twenty-first century. Although many older Americans will remain robust for most of their lives, a significant number will spend their last years coping with serious, complex, and chronic illnesses.

Indeed, persons with serious, complex, and chronic illnesses are among the most underserved and vulnerable patients in our country. The majority are aged 65 and older. Repeated studies conducted on these individuals report an unacceptably high prevalence of uncontrolled pain as well as other symptoms, poor communication between doctor and patient about medical care goals, and a significant burden for family caregivers.

Palliative care is a young and evolving specialty that focuses on relief of pain and suffering. Its goal is to help patients with a serious or advanced illness achieve the best possible quality of life, and to help their families cope, by utilizing an interdisciplinary team consisting primarily of doctor, nurse, and social worker. Increasingly, these health professionals are being trained and accredited to deliver palliative care.

Studies across a range of health care delivery settings have shown that palliative care programs effectively relieve pain and other distressing symptoms and improve patient and family satisfaction with their medical care. Palliative care can also reduce medical costs by improving the way the health care system allocates its resources, ensuring that the patient gets the right care in the right setting at the right time.

In recent years palliative care has grown rapidly as a medical specialty. However, there is a paucity of academic faculty physician specialists in the field capable of teaching medical students and residents the requisite knowledge and skills to provide effective palliative care. Consequently, seriously ill patients in the United States are subject to poor pain management and inappropriate or invasive medical interventions. Moreover, their physicians are not trained to help them or their family members deal with the psychological, emotional, and spiritual issues that accompany serious and life-threatening illnesses.

To meet the needs of a growing population of Americans who will require palliative care, a program must be developed to train experts who can in turn educate all physicians-in-training. An academic career award initiative would ensure that all medical students and residents receive vigorous and high-quality exposure to the principles of palliative care from well-trained experts in the field.

Private philanthropy has already had an enormous impact, contributing almost $250 million to date, with a significant amount supporting the development of academic faculty leaders in palliative care at medical schools and teaching hospitals. A major contributor has been the Open Society Institute's Project on Death in America. Unfortunately this program concludes in December of 2003, leaving a near total void in support for new faculty in palliative care.

The need for new sources of support for faculty development cannot be underestimated. Without new funding, the continued growth and

> "Although the world is full of suffering, it is also full of the overcoming of it."
>
> *Helen Keller*, Optimism (1903)

dissemination of the demonstrated improvement in quality of care associated with palliative care will not occur. It is therefore necessary and appropriate for the federal government, already the primary funder of physician medical education and training, to launch an initiative to support the field. In order to ensure that the physician workforce is prepared over the next several decades to respond to the care needs of the growing older and chronically ill patient population, there is no single intervention more important than ensuring a cadre of academic faculty at all of the nation's medical schools and teaching hospitals.

This report provides a blueprint for a faculty development initiative, based on existing models for other specialties, to produce effective palliative care leaders, educators, and researchers in academic medicine. The initiative assumes a modest annual investment, averaging $10.5 million, for 20 years to establish a core faculty in palliative care at every medical school in the United States. The total number needed is 480 faculty members (out of a national total of 100,000 medical school faculty).

Over the last ten years, private philanthropy has essentially created the palliative care field and continues to contribute to the support of endowed professorships, curriculum development, capital investments, and other initiatives. Now public funding sources must be found to ensure the continued existence of palliative care medical educators and researchers. This private-public partnership to establish a health care workforce trained in the principles of palliative care is an urgent priority for the nation.

Palliative Care Academic Career Awards

As our nation's older population grows, and as advances in technology prolong life, the need to provide appropriate care for individuals with chronic complex illnesses increases significantly. Palliative care is an important component of such care. It is the field of medicine that involves expert treatment of the physical, emotional, and spiritual issues associated with a serious and life-threatening illness.

Multiple national initiatives have focused attention on the need to improve pain and symptom management as well as providing psychological, social, and spiritual support for patients and families living with serious and complex illness. The field of palliative care has developed a substantial body of knowledge that addresses the needs of such patients and their families. However, the dissemination of this information and the acquisition of new knowledge has been limited because of the absence of academic palliative care teaching and research programs in the nation's medical schools and teaching hospitals. In 1997, the Institute of Medicine's (IOM) comprehensive report on end-of-life care, *Approaching Death: Improving Care at the End of Life*, called for fundamental changes in the content and quality of health professional education through the development of a "cadre of palliative care experts whose numbers and talents are sufficient to a) provide expert consultation and role models for colleagues, students, and other members of the health professions; b) supply leadership for scientifically based and practically useful undergraduate, graduate, and continuing medical education; and c) organize and conduct biomedical, clinical, behavioral, and health services research."[1]

This policy report further details the need to develop a cadre of academic faculty physicians who specialize in palliative care medicine. These new faculty will bring the core competencies of palliative care to all physicians-in-training and ensure its continued development. Quite simply, we need to provide quality education and training in palliative care for all physicians in order to ensure the best quality of health care for all Americans, now and in the future.

WHAT IS PALLIATIVE CARE?

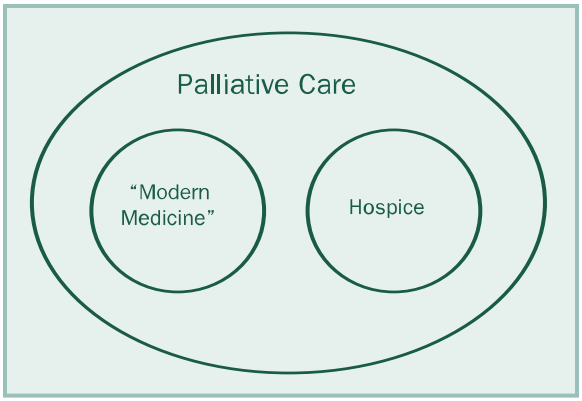
The goal of palliative care is to relieve suffering and improve the quality of life for patients with advanced illness. A broad interdisciplinary field encompassing, among others, the expertise of physicians, nurses, social workers, and clergy, palliative care is delivered simultaneously with all other appropriate medical treatments. The provision of such care involves managing physical and psychological symptoms as well as promoting social and emotional well-being through psychological and practical support for patients and their families. It comprises six major skill sets: symptom control, communication, decision-making, management of complications of disease and treatment, psychosocial care of patient and the family; and care of the dying.[2] Those trained in the field are expert in the

treatment of pain, anxiety, depression, dyspnea (breathlessness), nausea, fatigue, and other distressing symptoms. They are also able to sensitively provide accurate information, assist patients and families in making decisions, help coordinate appropriate care, and provide appropriate support during bereavement.

Palliative care can have a profound effect—helping to liberate sick individuals from discomfort and distress. It enables them to make the best possible use of their time, whether it is spent in a continued battle against the underlying illness or in living one's remaining life to the fullest. It provides individuals with the opportunity to resolve personal, familial, and spiritual issues.

A new field of medicine in the United States, palliative care grew out of the hospice movement in the 1970s, when many religious and secular charitable groups established centers to ease the suffering of the dying and to promote quality of life. In 1983, Medicare began covering hospice services, a development that spurred significant growth in the industry and established standards of care. Under Medicare and other insurers, eligibility for hospice is limited to those who are within six months of death and are willing to give up coverage for curative or life-prolonging treatment.

In contrast, palliative care applies the goals of hospice—attention to physical and emotional suffering, support for family members, help from a team of professionals—to a broader group of patients, independent of their prognosis and whether or not the patient is continuing to pursue life-prolonging treatments.



Currently, palliative care can be provided at home, in a hospice setting, in a nursing home, and, as has been seen more frequently in recent years, in hospitals. This is especially important since over 75 percent of the more than two million deaths each year in the United States occur in hospitals and nursing homes.[3] Although the great majority of individuals with serious illness are older, palliative care is not an age-specific field of medicine. People of all ages, including children with serious or fatal illness, urgently require physicians properly trained in palliative medicine. Furthermore, although palliative care is of primary importance for persons nearing the end of life, it is also critical in helping individuals who will live for years with a serious and complex illness (such as Alzheimer's disease, heart failure, and advanced lung disease).

More than 75 percent of Americans die in a hospital or nursing home, despite the fact that 90 percent say they want to die at home.

WHY IS PALLIATIVE CARE IMPORTANT?

The need to reduce pain and other sources of suffering

The Robert Wood Johnson Foundation's comprehensive 1990 study, SUPPORT (the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), highlighted

the lack of effective pain and symptom management strategies in hospitals. It documented that out of the 9,000 seriously ill hospital patients included in the study, about half reported moderate to severe pain at least half the time in the last three days of life.[4] The situation is even worse for nursing home residents, where studies have found that anywhere between 40 percent to 80 percent experience daily pain.[5] Studies have found that other symptoms in seriously ill individuals, including nausea and shortness of breath, are similarly undertreated. In addition to better managing physical pain and suffering, physicians trained in palliative medicine are equipped to communicate with patients and families under difficult circumstances, help them navigate the health care system, make decisions concordant with their goals and values, and receive care in the setting of their choice.

Almost half of dying hospitalized patients have substantial pain in the days before death.

The growing number of older Americans and the changing nature of disease and illness

One result of the resounding successes of modern public health and medicine is that today most individuals can expect to live a long life. In 2000, estimated life expectancy at birth reached 76.9 years (79.5 years for women and 74.1 for men), an increase in life expectancy of almost 30 years in the last century.[6] Those aged 65 and over constitute an increasingly large number and proportion of the U.S. population, numbering 35 million and accounting for 12.4 percent of the population, according to the 2000 U.S. Census. Roughly 75 percent of all deaths in the United States occur in this population.[6] By 2025, this population will almost double its size, rising to about 63 million, roughly 18 percent of our population.[7] In fewer than 25 years, the percent of Americans who are 65 and over will resemble that of Florida's current 65+ population.

These individuals comprise the majority of the disease burden in the United States and consume the majority of health care. Over 95 percent of the Medicare budget is spent on the health care of older persons with two or more chronic conditions. Moreover, the fastest-growing segment of this population is the 85-and-over group, which is at the highest risk of chronic, complex, and serious illness (including cancer, dementia, heart disease, stroke, and diabetes). This population will double in the next 25 years, from about four million to almost eight million. As a result of the rapid growth in numbers of older adults, the typical death is no longer a relatively sudden or unexpected event due to an acute illness. Rather, death frequently follows a lengthy period of chronic illness and functional dependency. Thus, most physicians will be treating chronically ill individuals whose medical care is characterized by high degrees of complexity, lengthy duration of illness,[1,8] and intermittent acute exacerbations interspersed with periods of relative stability. Palliative care should therefore be a core competency for all physicians, regardless of specialty, and an integral component of quality health care.

Increasing awareness of palliative care

Public recognition of and demand for access to palliative care has grown substantially, in part because of increasing media attention, such as the Bill Moyers series *On Our Own Terms: Moyers on Dying;* the efforts of advocacy groups to highlight the issue, including the Last Acts coalition of more than 1,000 groups (funded by

the Robert Wood Johnson Foundation); and growing dissatisfaction emanating from personal and family experiences with the current health care system. The notion that suffering before death is inevitable is increasingly becoming unacceptable. Patients and families are coming to expect the same expert and sophisticated attention to symptom distress that they are accustomed to receiving for life-prolonging and curative treatments.

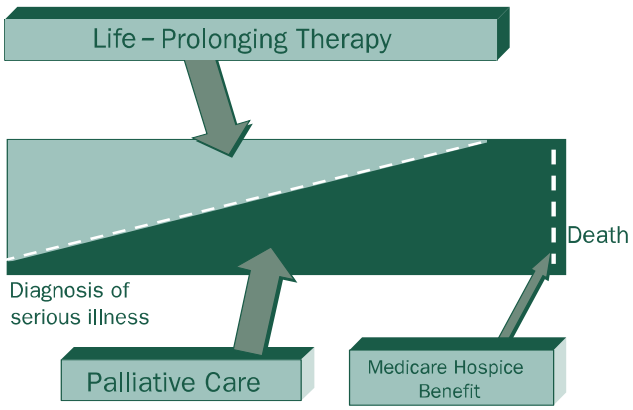
Cost-effectiveness of palliative care

In addition to being a core component of quality care, evidence exists that effective provision of palliative care can reduce the cost of care. In hospitals, a palliative care program facilitates the transition of patients to more appropriate care settings, leading to increased bed capacity and reduced costs through shorter lengths of stay and lower ancillary and pharmacy costs. A study at Mount Sinai Medical Center in New York evaluated more than 500 Medicare patients who died there in 2001, both with and without the help of the institution's palliative care program, and found that the palliative care patients spent fewer days in the hospital, which produced cost savings of more than $750,000.[9] Palliative care in other settings also has been shown to reduce costs. For example, the Kaiser Hospice and Home Health program in California performed a comparative study involving 300 patients who died and found that the average daily cost for patients in the palliative care program was $62 compared with $133 for those receiving regular care, primarily because those in the palliative care program received more of their care at home than in the hospital.[10] Multiple other studies have demonstrated that palliative care programs reduce symptom distress, improve patient and family satisfaction, and ensure cost-effective care by delivering the right care to the right patient at the right time in the right place.

WHO BENEFITS FROM PALLIATIVE CARE?

The populations served by palliative care include individuals of all ages living with a serious illness. About 20 percent of persons with terminal illness in the United States are referred to hospice under the Medicare Hospice Benefit. Because the Medicare Hospice Benefit requires a prognosis of six months or less as well as a decision to forego life-prolonging treatments, the majority of persons with serious, complex, and chronic illness do not avail themselves of hospice. Among those who do receive hospice care before death, the median length of stay is 17 days. Obviously, palliative care is needed for much longer than 17 days and for many more patients than those who take advantage of hospice in their last few weeks of life. Patient populations that would particularly benefit from widespread physician education and training in palliative care include frail older people, children, minorities, and those with HIV/AIDS. In each of these groups abundant evidence points to systematic underrecognition and undertreatment of palliative care needs, including pain assessment and treatment.

Palliative Care's Place in the Course of Illness



Frail older people are undergoing exponential growth both in numbers and in the multiplicity of their health care needs, with a high prevalence of chronic degenerative illnesses. Patients with dementia, stroke, heart disease, diabetes, and renal failure generally do not have a predictable prognosis and continue to benefit from, and to want, efforts focused on prolonging their lives. These individuals receive little effective palliative care. They are ineligible for the Medicare hospice benefit since the patients who apply for this benefit must agree to give up coverage for life-prolonging therapies and a physician must certify that they have a likely life expectancy of less than six months.

Seriously ill children often fail to receive competent and compassionate care that meets their needs. A recent IOM report, *"When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families,"* discusses the current shortcomings.[11] Deficits in palliative care for children parallel those experienced by adults, including inadequate assessment of pain, confusing prognosis and treatment options, and lack of guidance and advice with regard to care goals. The report highlights the need for all health care professionals who work with children and their families to have basic competence in palliative and end-of-life care.

In addition, several studies have documented disparities in pain and palliative care treatment based on race and ethnicity. For example, one study found that physicians underestimated and undertreated pain in 64 percent of Hispanics and 74 percent of African Americans with cancer.[12] Other studies report similarly inadequate pain management and treatment of other symptoms in minority populations.[13] The reasons for these disparities in palliative care are unclear, but they reflect the broader issue of racial disparities in health care. These populations would be among the first to benefit by ensuring that all physicians are well trained in all aspects of palliative care.

Misguided Fears of Addiction

One barrier to the effective treatment of pain involves the issues surrounding the use of controlled substances, such as strong opioids like morphine and Oxycontin. Misguided fears of addiction and abuse have stigmatized these drugs; physicians are reluctant to prescribe them and patients are fearful of becoming addicted. Moreover, regulatory efforts to combat drug abuse can interfere, unintentionally or otherwise, with medically appropriate use of these substances. This is unfortunate, as these opioids can provide great improvement in the quality of life for seriously ill patients.

A significant body of research exists regarding drug tolerance and physical and psychological dependence, indicating that analgesics can be taken for a long period of time without loss of effectiveness. Moreover, such opioids can be effectively administered to seriously ill patients with minimal risk of addiction. Many people fear that taking an opioid will affect their thoughts and actions, leaving them unable to function even if the pain is relieved. This is not the case, however. Most patients can take these medicines for a long period of time without untoward effects. Those side effects that do occur can be effectively managed.

A cadre of leaders in palliative care will help change attitudes and behaviors toward pain management by educating other physicians and the general public about the harmful effects of uncontrolled pain and the benefits of opioids, as well as dispelling unnecessary concerns about their use. This will also support the development of advocacy strategies to further remove the barriers to quality health care for individuals in pain.

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There is also a growing body of evidence demonstrating undertreatment of pain in patients with AIDS. Thanks to new therapies, AIDS patients in the United States typically live for years after diagnosis; however, 80 percent of individuals with the disease report moderate to severe pain.[14] Physicians caring for these patients have identified three major barriers to effective care: lack of knowledge of pain management, lack of access to pain management specialists, and concerns about the use of opioids.[15] Education in palliative care would eliminate these barriers.

The diversity of these populations at risk shows that palliative care is intergenerational, crosses diagnostic categories, and is based on the needs of the patient, not on his or her prognosis or willingness to give up life-prolonging treatment. It is relevant to everyone who has or may develop a serious illness. The broad spectrum of Americans with palliative care needs underscores the importance of the field and the need for high-quality physician education and training. Medical school faculty specializing in palliative care are needed to ensure that future health professionals have expertise in this kind of care.

WHAT IS THE STATUS OF PALLIATIVE CARE EDUCATION AND TRAINING?

The importance of education and training

Physicians must be well trained to provide relief of pain and other symptoms and to provide an appropriate level of care. They must learn how to attend to the burdens of family caregivers and communicate effectively with the patient and family. Finally, physicians must be trained to help negotiate the fragmented health system that makes the provision of medical care for seriously ill patients difficult and distressing for patients, families, and physicians alike. Further, the transition from chronically ill to seriously ill to dying is often gradual and perceptible only in retrospect.

Thus almost all physicians require training to enable them to accompany their patients from diagnosis to chronic illness to dying and death. The skills required to competently deliver this kind of longitudinal, comprehensive, and high-quality medical care are embodied in the discipline of palliative care, which is relevant to all physicians and transcends all specialties.

▶A Case Study

Dr. J. was just assigned to care for Mrs. M., a hospitalized 82-year-old woman with hypertension, diabetes, osteoporosis, and vision loss. Mrs. M. had fallen three weeks before, breaking her hip and requiring hospitalization. During her current stay at the hospital her condition grew progressively worse, as she developed pressure ulcers and recurrent infections. She persistently moaned in pain and resisted efforts to reposition or transfer her to change her dressings. She also was not eating and was losing weight. Her family was increasingly alarmed and upset about her deterioration. Fortunately, Dr. J. had received training in the principles of palliative care. He carefully assessed Mrs. M. and then met with Mrs. M.'s family (her son was her health proxy) to clarify the goals of her care and to help select the medical treatments to meet the goals. The family's first priority was to ease her pain and discomfort. Dr. J. prescribed an appropriate opioid pain reliever, given Mrs. M.'s age and other medications. Shortly after, the moaning was curtailed and Mrs. M. consented to be moved. Dr. J. then discussed the next steps in her care plan, recommending placement in a skilled nursing facility, where she could begin rehabilitation. A few days later a bed became available in such a facility, and Mrs. M. was transferred. She was soon eating and interacting with her family members, who were very satisfied with the care plan.

Recognition of need for education and training
According to a recent study, "The Supply, Demand, and Use of Palliative Care Physicians in the United States," by the Center for Health Workforce Studies,[16] which surveyed physicians, hospitals, and medical schools, a majority of respondents agreed that it is extremely important to increase education in palliative care for all physicians. Established protocols and practices for palliative care, that is, symptom identification and management, communicating difficult information to patients and family, and developing goals and plans for appropriate care, must be taught in order to be applied appropriately. The key is to effectively integrate this knowledge and information into the medical education system—a goal that requires medical school faculty specializing in the field.

The lack of education and training in palliative care
Despite the growth in public and professional awareness of the importance of palliative care and a rise in institutional interest and capacity, there has been only a slight increase in medical professional training opportunities in the field. Curricula in U.S. medical schools and in residency training programs contain minimal formal coursework related to death and dying. According to the *Association of American Medical Schools Curriculum Directory* in 1998–99, only two schools required a separate course in palliative care, and only 30 offered a separate elective.[17] Most schools incorporate palliative care into other courses, where it is often overshadowed by other topics. Moreover, according to the IOM report *Approaching Death,* "the residency years bring a negative image of dying patients and a neglect of excellence in end-of-life care."[18] Indeed, 74 percent of medical residency programs in the United States offer no training in end-of-life care whatsoever.[19]

Other Professions Need Leaders in Palliative Care

Although this report focuses on physician education and training in palliative care, the importance of nurses, social workers, and others in providing such care should not be overlooked. Although these professions have not been as severely criticized as the medical profession for inattention to care at the end of life, they too need to train students in the principles of palliative care.

Nurses at all levels have a vital role in the delivery of palliative care and are involved in many of the same issues as physicians, including pain and symptom management; psychosocial, spiritual, and culturally sensitive care of patients and their families; patient education and advocacy; bereavement care; ethical and legal considerations; and communication skills. Unfortunately, nurse education can also be faulted for insufficiently preparing nurses to understand the needs of seriously ill and dying patients. Nurse educators are therefore needed to improve nursing education in palliative care. One example is an initiative sponsored by the Robert Wood Johnson Foundation called the End-of-Life Nursing Education Consortium (ELNEC), which seeks to develop a core of expert nursing educators and to coordinate national nursing education efforts in end-of-life care.

Social workers generally play a central role in counseling and case management for patients and families. Like physicians, however, surveys of social workers show that they receive little education and training in palliative care, although they indicate interest in such training. Moreover, there are few social work academics who could function as role models. The profession would also clearly benefit from more leaders in palliative care, which would enhance exposure to the field among social work students.

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American Association of Colleges of Nursing. End-of-Life Nursing Education Consortium (ELNEC) Project. For more information, go to www.aacn.nche.edu/elnec/index.htm.

A forthcoming paper highlights the current lack of exposure to the field by physicians. This report, *The Status of Medical Education in End-of-Life Care: A National Report*,[20] presents the results of a survey of medical school students, residents, and faculty on end-of-life care. The report finds that few students and residents received, and few faculty provided, formal end-of-life care education or training. Moreover, students and residents viewed the quality of end-of-life teaching as lower than that of the general quality of teaching. The study concludes that despite "nearly universal agreement that physicians have a responsibility to help patients prepare for death, students and residents in the U.S. feel unprepared to provide many key components of good care for the dying."

Seventy-four percent of medical residency programs in the United States offer no training in end-of-life care.

Efforts to promote education and training

The situation is not all negative however. Palliative care is a new field of medicine, and given its short history there has been significant progress. There are now 37 palliative care fellowship training programs in the United States,[21] although they vary in quality and are generally small in size (i.e., one or two fellows per year).[22] In addition to support from private foundations, the federal government and the Veteran's Administration have committed resources to support fellowship training and patient-oriented research in palliative care. Recently, a collaborative effort involving the directors of the fellowship training programs, the American Board of Hospice and Palliative Medicine, and the American Academy of Hospice and Palliative Medicine have produced a set of guidelines for postgraduate fellowship training programs in palliative care that should make a major contribution to standardizing and improving the quality of existing and future programs.[23] The Education for Physicians on End-of-Life Care (EPEC) Project was launched in 1999 to teach practicing physicians how to better provide care to terminally ill patients.[24] To date, it has trained more than 1,400 physicians and other providers in palliative care through a three-day intensive exposure.

The postgraduate fellowship programs are necessary to train palliative care specialists, and the EPEC project is important in providing continuing medical education to practitioners. However, neither are structured to prepare graduates to pursue careers in academic medicine, nor have they begun to meet the need to place faculty in leadership positions at our nation's medical schools. Support for junior faculty is required to produce the faculty leaders necessary to ensure the training of future generations of both generalist and specialist palliative care physicians.

The Project on Death in America (PDIA), sponsored by the Open Society Institute, has played a key role in supporting the development of palliative care faculty in the nation's medical schools. The PDIA Faculty Scholars Program supports academic faculty who are clinician-researchers and educators committed to improving palliative care. The goal is to promote the visibility and prestige of these individuals and enhance their effectiveness as academic leaders and role models. Since it was established in 1995, the PDIA has funded 87 faculty scholars in 58 medical and nursing schools in the United States and Canada. These faculty scholars have contributed more than 1,800 publications to the field and have garnered more

than $113 million in grant funding to support research, education, and program development in hospice and palliative care. By teaching students, residents, fellows, and other faculty, they are building the science base for the field and reaching out to educate the public and to serve in advocacy. Unfortunately, the PDIA program and its support for physician faculty will conclude in December 2003, leaving a near total void of sources of support for palliative care faculty development.

THE NEED FOR FEDERAL SUPPORT FOR PALLIATIVE CARE FACULTY DEVELOPMENT

In order to sustain and develop the field of palliative care, a sufficient number of medical school faculty specializing in the field is required. This cadre of palliative care medical school faculty can be created by implementing a modest faculty development program supported by the federal government. As the federal government is already the primary funder of physician education and training, this initiative fits well within the realm of existing activities.

Out of more than 100,000 total medical school faculty members in the United States, fewer than 100 specialize in palliative care.

In fact, a similar program already exists to support the development of academic geriatricians, called the Geriatric Academic Career Award (GACA), administered by the Health Resources and Services Administration (HRSA). The GACA provides training with up to five years of partial salary support for junior faculty who wish to continue in academic geriatrics after their fellowship. Since it began awarding grants in 1999, the GACA has proved to be a highly successful and popular model. In only two rounds of grants, it has produced 35 awardees. This number will increase significantly in the future as a result of new applications and new funding. The 35 awardees work in medical schools around the nation, conducting research, educating students and residents, and substantially enhancing the field of geriatrics. In addition, private philanthropies, such as the Brookdale Foundation, the John A. Hartford Foundation, and the Donald W. Reynolds Foundation have contributed significant resources to complement the public funds (i.e., supporting the construction of buildings, endowed professorships, curriculum development). The continued development and growth of geriatrics through collaborative private and public funding initiatives is a good example of a successful public-private partnership.

Building on the successful faculty scholars program of the PDIA and the success of the GACA model, a similar faculty development initiative is needed in order to sustain and promote the field of palliative medicine. As is the case with geriatrics faculty training, the private sector has supported the initial development of palliative medicine, but a sustained commitment by the federal government is necessary. A palliative care academic career award (PACA) would help accomplish this objective by supporting, for up to five years, the career development of medical school faculty as palliative care academicians. These individuals will develop skills in research and education in palliative medicine, ensuring the education of future generations of physicians, research regarding key questions facing the field, and, indeed, the continued existence of the field.

The ultimate goal is to establish at least three permanent faculty members at all 144 medical schools, allopathic and osteopathic, entailing a minimum of roughly 435 palliative care faculty members. Some schools with larger research programs would be able to accommodate additional faculty members. At present, out of more than 100,000 total medical school faculty members in the United States, fewer than 100 specialize in palliative care, the majority of whom were supported by the PDIA. A palliative care academic career award would award $75,000 per year in salary support, similar to awards made by the NIH for career development in other fields.

Table 1

Year	New candidates	Candidates per year (5% attrition)	Cost per year	Number completing five years (cumulative)
1	15	15	$1,125,000	0
2	15	29	$2,175,000	0
3	15	44	$3,300,000	0
4	25	68	$5,100,000	0
5	25	92	$6,900,000	14
6	25	101	$7,575,000	29
7	35	121	$9,075,000	43
8	35	140	$10,500,000	67
9	35	149	$11,175,000	90
10	40	164	$12,300,000	114
11	40	178	$13,350,000	147
12	40	183	$13,725,000	181
13	40	187	$14,025,000	214
14	40	192	$14,400,000	252
15	40	192	$14,400,000	290
16	40	192	$14,400,000	328
17	40	192	$14,400,000	366
18	40	192	$14,400,000	404
19	40	192	$14,400,000	442
20	40	192	$14,400,000	480
			$211,125,000	

Total number of academic faculty after 20 years: 480
Average cost per year: $10.5 million

Table 1 depicts how a cadre of palliative care academics can be created. Based on HRSA's experience with the GACA, it is safe to assume that roughly 15 qualified candidates would receive the award each year. The algorithm projects that the annual number of new candidates will grow incrementally to reach 40 by the tenth year, taking into account an attrition rate of 5 percent. At the end of 20 years, this effort will produce 480 medical school-based palliative care faculty, ensuring a minimum of three faculty members at every medical school. Again, schools with larger programs would benefit from the additional positions made available by the initiative. The cost of developing these faculty members would average about $10.5 million per year over 20 years, with a maximum of slightly less than $15 million annually. Although this basic algorithm does not account for any cost-of-living adjustments, it is a modest amount of federal funding, in the context of the enormous growth in numbers of patients in need of palliative care and the hundreds of millions of dollars already spent each year by the federal government on health professions training programs. It would also be advisable to provide an additional stipend to help defray administrative expenses. For example, the NIH K23 award provides up to $25,000 per year for research expenses, travel to research meetings, and statistical services.

Private philanthropy is expected to continue its support for complementary efforts to build the field, including endowment for professorial chairs, curriculum development, and construction of buildings and facilities. A public-private initiative is crucial, as neither element alone can achieve the desired goal.

A cadre of fewer than 500 palliative medicine faculty is sufficient to ensure the stability, quality, and sustainability of academic palliative care as an area of central importance in medical education

and health care. These individuals will conduct the research needed to advance the science of the field and will disseminate this knowledge to new generations of physicians in medical school, residency, and fellowship programs.

CONCLUSION

All physicians must have rigorous and high-quality education and training in the content, attitudes, and skills of palliative care. The development of a national cadre of academic physician medical school faculty specializing in palliative care will ensure that the principles of the field are mainstreamed into the medical education and training process. Given the increasing demands placed on our health care system by an aging population, it is urgent that this public-private effort begin as soon as possible.

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